# Chapter 3 -- Enrollment and Disenrollment Policies (OPL99.100)



## Section 7.0 -- Post-Enrollment Activities

Some M+COs verify information before enrollment information has been transmitted to HCFA. In these cases the M+CO may find that it must make corrections to an individual's enrollment form. The M+CO should make those corrections, and the individual making those corrections must place his/her initials next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the M+CO (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These type of corrections will not result in the M+CO having to co-sign the enrollment form (as described under section 4.1).

## 7.1 -- Multiple Transactions

Multiple transactions occur when more than one election for the same individual with the same effective date is received by HCFA. An individual may not be enrolled in more than one M+C, cost, or HCPP plan at any given time. In addition, if an individual elects more than one plan for the same effective date, it is not always clear with which plan the individual truly intended to be enrolled. Therefore, M+COs will occasionally receive reply listings that show rejections for multiple transactions.

To ensure an individual's intent is identified when s/he elects multiple plans, and to educate individuals on the impact of multiple transactions, retroactive enrollments will not be processed for multiple transactions. Only current enrollments will be allowed for correction of multiple transactions (i.e., no retroactive enrollments will be allowed under these circumstances). If a Medicare eligible individual has used M+C plan services and the enrollment is rejected for multiple transactions, then the M+CO may bill Medicare for the services. The M+CO may bill for Part B services from the Medicare carrier (Note: the M+CO must have an indirect billing number from HCFA). Or, the M+CO may have its certified M+C plan providers bill for Part B services. The certified M+C plan providers may bill the Medicare fiscal intermediary for Part A services. M+COs may not bill for Part A services.

Upon availability of the reply listing from HCFA showing a rejection for a multiple transaction, the M+CO may contact the individual to determine in which M+C plan the individual wishes to enroll. Once the individual has chosen one M+C plan, s/he must either fill out and sign another enrollment form or send written notice of his/her intent to enroll in the plan (to serve as supporting documentation to the original enrollment form

signed by the individual), and the M+CO may transmit the information to HCFA with a current effective date, using the appropriate effective date as prescribed in section 3.5.

Note: as supported by section 3.5, if multiple transactions occur for elections made during an OEP, M+COs must enroll the individual for the same month that initially rejected if the new completed enrollment form is received in the same month the original enrollment request was received. However, they may not provide an effective date of coverage of the same month that initially rejected if the new completed enrollment form is received the following month.

- For example, two M+C plans receive completed enrollment forms from one individual on May 2 for a June 1 effective date, both elections are transmitted by the May cutoff date and are subsequently rejected, and the individual fills out a new enrollment form for the M+C plan of choice. If that completed enrollment form is received by the M+C plan no later than May 31, then the effective date of coverage is June 1. However, if the completed enrollment form is received June 2, then the effective date of coverage is July 1.

## 7.2 -- Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Cancellations can only occur prior to the effective date of the election.

If a cancellation occurs after HCFA records have changed, retro-disenrollment and reinstatement actions may be necessary. Refer to sections 7.3 and 7.5.

### 7.2.1 -- Cancellation of Enrollment

An individual's enrollment can only be canceled if the request is made prior to the effective date of the enrollment. The M+CO should ensure the cancellation occurs and should not transmit the enrollment to HCFA or, if it has transmitted the enrollment, should attempt to submit a corresponding disenrollment transaction to HCFA in order to cancel out the enrollment transaction. In the event the M+CO has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, the M+CO should contact the HCFA RO in order to cancel the enrollment.

When canceling an enrollment the M+CO must send a letter to the individual that states that the cancellation is being processed. The notice must inform the member that if he/she was already enrolled in another M+C plan, then the current enrollment action may have resulted in his/her being disenrolled from that M+C plan. The notice must also instruct the individual to contact the original M+C plan if he/she wishes to remain a member of that M+CO.

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation cannot be processed. The M+CO must inform the member that if

he/she was enrolled in another M+C plan, then the current enrollment action will result in his/her being disenrolled from that M+C plan. The M+CO must also instruct the individual to contact the previous M+C plan if he/she wishes to remain a member of that M+CO. If the member wants to return to original Medicare, the member must be instructed to make a written request to disenroll from the M+CO during an election period (described in section 3.0), and with a current effective date, using the appropriate effective date as prescribed in section 3.5.

### 7.2.2 -- Cancellation of Disenrollment

A member's disenrollment can only be canceled if the request is made prior to the effective date of the disenrollment. The M+CO should ensure the cancellation occurs and should not transmit the disenrollment to HCFA or, if it has transmitted the disenrollment, should attempt to submit a corresponding enrollment transaction to HCFA in order to cancel out the disenrollment transaction. In the event the M+CO has submitted the disenrollment and is unable to submit a corresponding enrollment transaction, the M+CO should contact the HCFA RO in order to cancel the disenrollment. The M+CO must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using M+C plan services.

If the member's request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in section 7.3.2. If a reinstatement will not be allowed, the M+CO should instruct the member to fill out and sign a new enrollment form to re-enroll with the M+CO during an election period (described in section 3.0), and with a current effective date, using the appropriate effective date as prescribed in section 3.5.

## 7.3 -- Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to section 5.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are: (1) disenrollment due to erroneous death indicator, (2) disenrollment due to erroneous loss of Part A or Part B indicator, and (3) mistaken disenrollment.

When a disenrolled member contacts the M+CO to state that s/he was disenrolled due to any of the reasons listed above, and states that s/he wants to remain a member of the M+C plan, then the M+CO must instruct the member to continue to use M+C plan services (refer to Exhibits 15, 16, and 17 for model letters).

### 7.3.1 -- Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Part A or Part B Indicator

A member can be reinstated if s/he was disenrolled due to an erroneous death or loss of Part A or Part B indicator since s/he was always entitled to membership. As outlined in

42 CFR 422.74(c), M+COs have the option of sending notification of disenrollment due to death or loss of Part A or B. HCFA strongly suggests that M+COs send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibits 13 and 14 for model letters.

To request reinstatement from the HCFA RO, the M+CO should submit the following information to its RO:

1. A copy of the reply listing showing the disenrollment (include the system run date).
2. A copy of any disenrollment letter that the M+C plan may have sent to the individual (see sections 5.2.2 and 5.2.3). Refer to model letters in Exhibits 13 and 14.
3. A copy of any correspondence from the member disputing the termination. Member correspondence could include a summary of the dispute, phone contact reports, and copies of letters.
4. A copy of the letter to the member informing him/her to continue to use M+C plan services until the issue is resolved. Refer to model letters in Exhibits 15 and 16.
5. Verification that the termination was erroneous. This verification can be shown via documentation from SSA stating its records have been corrected or that its records never showed the member as being deceased or having lost entitlement. It may also be shown by a Litton/MCI World Comm Advanced Networks HI Mini Master or GHP or CWF print screen supporting the uninterrupted existence of Part A or B enrollment.

## 7.3.2 -- Reinstatements Due to Mistaken Disenrollment Made By Member

As stated in section 5.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. The only exception is for those members who are able to cancel the disenrollment, before the effective date of the disenrollment (as outlined in section 7.2.2), given that this type of cancellation generally results in no changes to HCFA records.

Reinstatements will be allowed at the request of a member who enrolled in a second M+CO, which resulted in automatic disenrollment from the original M+CO in which s/he was enrolled, and who was unable to cancel the enrollment in the second M+CO (as outlined in section 7.2.1). However, these reinstatements will only be granted if the member submits the request for reinstatement in writing in the time frames described in the next paragraph and has only used health care services from providers in the original M+C plan (not including emergency or urgently needed services) since the original effective date of the disenrollment.

In these cases, when a disenrolled member contacts the original M+CO to state that s/he mistakenly disenrolled, and states that s/he wants to remain a member of the M+C plan,

then the M+CO must instruct the member to notify the M+CO in writing of the desire to remain enrolled in the plan within 30 days after the availability of the reply listing showing the disenrollment. The M+CO must instruct the member to continue to use M+C plan services (refer to Exhibit 17 for a model letter). If the M+CO does not receive the written statement requested from the member within the required time frame, then it must close out the reinstatement request by notifying the individual of the denial of reinstatement (refer to Exhibit 18 for a model letter).

To request reinstatement from the HCFA RO, the M+CO must submit the following information to its RO:

1. A copy of the reply listing showing the disenrollment (include the system run date).
2. A copy of the disenrollment letter sent to the individual. Refer to model letter in Exhibit 12 (or Exhibit 11, if appropriate).
3. A copy of any correspondence from the member disputing the disenrollment and indicating that s/he wants to remain enrolled in the plan. Member correspondence could include a summary of the facts, phone contact reports, and copies of letters.
4. A copy of the letter to the member informing him/her to continue to use M+C plan services until the issue is resolved and instructing him/her to state the intent to continue enrollment in writing. Refer to model letter in Exhibit 17.
5. A copy of the written statement from the member indicating s/he wants to remain enrolled in the M+C plan and has not used non-plan services (except for emergency or urgently needed services).

## 7.4 -- Retroactive Enrollments

The HCFA ROs will only process requests for retroactive enrollments when the M+CO has notified the member that s/he must use M+C plan services during the period covered by the retroactive enrollment request. Retroactive enrollments will be approved by the HCFA RO when an individual has fulfilled all election and eligibility requirements for an M+C plan but the M+CO or HCFA is unable to process the election for the statutorily required effective date (as outlined in section 3.5).

The following documentation must be submitted to the RO for all retroactive enrollment requests. The retroactive enrollment request should be made within 45 days of the availability of the first reply listing.

1. Copy of signed completed enrollment form. Note: the form must have been signed by the applicant prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage.
2. Copy of M+CO's letter to the member acknowledging receipt of the completed enrollment form and notifying the member to begin using the M+C plan's services as of the effective date (refer to Exhibit 4 for the model letter). The letter must be dated prior to the requested retroactive effective date of coverage (or, when

appropriate as outlined in section 4.2, within 5 business days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

The following documentation should also be provided:

3. One or more of the following: Verification of Medicare entitlement (refer to section 1.0 regarding what is acceptable "evidence of Part A and Part B coverage").
4. For cases of erroneous indicator of no Medicare entitlement: Copies of two reply listings, including a copy of the system run date, indicating the M+CO's attempts to correctly enroll the individual and the resulting rejections. One reply listing will be considered acceptable if the M+CO would be unable to obtain a second reply listing and still submit the retroactive enrollment request within 45 days of the availability of the first reply listing; however, two reply listings are preferred. In the event reply listings are not available, the M+CO may submit the McCoy exception report. The effective date on the first reply listing must correspond with the anticipated effective date, in order to effectuate the requested effective date of coverage.
5. For cases of erroneous indicator of ESRD, either because the individual has never had ESRD or because ESRD has been terminated:
    A. Evidence of contact with the individual after the first systems rejection, including the individual's explanation for rejection. If the individual reports that the ESRD status is completed or that s/he has had a kidney transplant or no longer receives dialysis services, then provide medical documentation, i.e., letter from the physician or dialysis facility that documents date of transplant or last month of dialysis. If the individual reports that s/he never had ESRD, provide a statement signed by the individual (or his/her physician) to that effect.
    B. A copy of the reply listings or GHP or Litton/MCI World Comm Advanced Networks HI Mini Master print screens indicating the M+CO's attempts to correctly enroll the individual and the resulting rejection. The effective date on the reply listing must correspond with the anticipated effective date, in order to effectuate the requested effective date.

In the event that HCFA determines that the M+CO did not notify the member that s/he must use M+C plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request will not be processed. In this case, if the Medicare eligible individual has used M+C plan services during the period covering the retroactive enrollment request, the M+CO may bill Medicare for the services. The M+CO may bill for Part B services from the Medicare carrier (Note: the M+CO must have an indirect billing number from HCFA). Or, the M+CO may have its certified M+C plan providers bill for Part B services. The certified M+C plan providers may bill the Medicare fiscal intermediary for Part A services. M+COs may not bill for Part A services.

## 7.5 -- Retroactive Disenrollments

HCFA may grant a retroactive disenrollment if an enrollment was never legally valid (section 4.6) or if a valid request for disenrollment was properly made but not processed or acted upon (as outlined in the following paragraph), which includes not only system error but plan error (see section 1.0 for a definition of "system error" and "plan error"). HCFA may also grant a retroactive disenrollment if the reason for the disenrollment is related to a contract violation (as outlined in 42 CFR 422.62(b)(3)). Retroactive disenrollments can be submitted to HCFA by the beneficiary or a M+CO. Requests from a M+CO must include supporting evidence justifying a late disenrollment. M+COs must submit retroactive disenrollment requests to HCFA RO as soon as possible. If the HCFA RO is not able to resolve system errors, the recommendation is submitted to HCFA Central Office for correction. If HCFA approves a request for retroactive disenrollment, the M+CO must return any premium paid by the member for any month for which HCFA processed a retroactive disenrollment, and must return to HCFA any capitation payment for the retroactive period.

A retroactive request may be submitted to HCFA by the member in cases in which the M+CO has not properly processed or acted upon the member's request for disenrollment as required in section 5.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in section 3.6.

If a M+CO is making a retroactive request that is a result of M+CO error or system problems (as defined in section 1.0) in which the disenrollment is not recorded on a timely basis by the M+CO or in HCFA records, the M+CO must submit the request to:

- HCFA central office, for a HCFA or SSA computer system problem involving multiple members, or
- HCFA RO, for individual cases or situations when the plan is experiencing internal problems.

The M+CO should submit a retroactive disenrollment request to the HCFA RO for errors made by SSA in submitting plan disenrollments. HCFA makes an adjustment of the dates. If the M+CO is uncertain which HCFA office should process the request, the M+CO should contact the HCFA RO.

## 7.6 -- Retroactive Transactions for Employer Group Members

In some cases a M+CO that has both a Medicare contract and a contract with an EGHP arranges for the employer to process elections by Medicare-entitled group members who wish to make elections under the Medicare contract. However, there can be a delay between the time the member makes the election through the EGHP and when the election is received by the M+CO. Therefore, retroactive transactions may be necessary.

## 7.6.1 -- EGHP Retroactive Enrollments

HCFA will allow the M+CO to submit the EGHP enrollment to HCFA with retroactive enrollment dates of up to 90 days before the date the enrollment form was received by the M+CO. However, the effective date cannot be prior to the signature date on the election form. In addition, the effective date cannot be during a time period in which the M+C plan was closed for enrollment. For example, if the M+C plan was closed in the month of April and received an EGHP enrollment form in May for an April 1 effective date, the M+C plan must not process the enrollment with an April 1 retroactive effective date.

No retroactive enrollments may be made unless the individual certifies that the M+CO (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The M+CO should submit such enrollments using a number 60 enrollment code. Refer to Chapter 19 for more detail on the use of code 60.

## 7.6.2 -- EGHP Retroactive Disenrollments

The M+CO must submit a retroactive disenrollment request to the HCFA RO if an employer does not provide the M+CO with timely notification of a Medicare retiree's requested disenrollment. Up to 90 day's retroactivity before the date the M+CO receives the request is possible in such a case. The employer notification is considered untimely if it does not result in a disenrollment effective date as outlined in section 3.6.

The M+CO must submit a disenrollment notice (i.e., documentation) to HCFA demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively) but that the employer was late in providing the information to the M+CO. Such documentation may include an enrollment form signed by the member and given to the employer during an open enrollment season. (Note that the enrollment form could be the employer's generic form used during its open enrollment season for all employees and retirees. The M+CO should not confuse it with the HCFA approved enrollment form used by the M+CO). Such documentation must be sent to the HCFA RO within 15 days of receipt of the completed disenrollment request from the EGHP.

## 7.7 -- Election of the Continuation of Enrollment Option

When a member moves out of the M+C plan service area and permanently into the M+CO's continuation area, the member must make a positive choice to continue enrollment in the M+C plan. The member must make this choice in writing, but does not have to complete and sign a new enrollment form in order for the continuation to occur.

The M+CO must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the M+CO may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the month the individual moves into the continuation area.

## 7.8 -- Medicare MSA Plans

Medicare MSA plans must follow the procedures outlined in sections 7.1 through 7.7.